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Chapter 6 Temporal Bodies: Emergencies, Emergence, and Intersex Embodiment

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Introduction

Intersex people include a wide range of physical variations that at the gonadal, hormonal or chromosomal level gives the individual a combination of masculine and feminine characteristics. Some intersex variations present at birth where the child's genitalia appear 'ambiguous' in terms of sex. In these cases, the medical profession presents parents with the dilemma of whether or not the child should undergo gender-normalizing surgery and, if so, when (Groveman 1998; Chase 1998). While this decision must be made in the child's best interests, there is widespread concern that healthcare is inappropriately framing intersex embodiment as an emergency requiring action and intervention in order to 'fix' the child and subsequently end the emergency. Troublingly, even within healthcare literature and guidelines, the main emergency that medical professionals are responding to is not the intersex variations themselves (which are routinely benign - Zillén et al 2017) but are instead aimed at managing societal and familial reactions to intersex variations. Surgical interventions to 'correct' the intersex variation are, in the majority of circumstances, therefore medically unnecessary. Moreover, research has demonstrated that these procedures are harmful and consequently, in the absence of the individual's consent, these medical interventions have been declared to be manifest breaches of human rights by both the academy and International Human Rights Bodies. Nevertheless, States are failing to prohibit such practice and healthcare continues to routinely offer bio-medical 'solutions' in the form of 'normalising' genital surgeries to 'fix' social emergencies. Indeed, in the English and Welsh context at present, juridical and clinical assessments of best interests have done little to afford intersex embodied infants any real protections from these gender-normalising interventions. This chapter is, therefore, part of a broader project by the authors to explore the systemic reasons as to why States are failing to disrupt medical power/knowledge in this area and consider how States can be compelled to act.

In particular, this chapter reflects on the way in which the medical profession uses time, or rather temporality to prevent threats to its power/knowledge in this area. Time is a measurement through which we measure change or duration and is usually measured as progression into the future while present events are continuously relegated to the past. In contrast, temporality refers to the way in which time is experienced or constructed. Bodies are, consequently, always temporal. Institutions, such as healthcare, the law, or the family, in which bodies are continuously embedded and dependent, generate multiple modes of temporality that are crucial to the ways that bodies are understood within society. These institutional temporalities have an important effect on the distribution of resources and responsibilities as they dictate how the state responds to these issues. Whilst some public health responses, for example, are understood in terms of 'crises' and thus deserving of immediate financial investment, other issues, that could be the subject of public health interventions are constructed as 'normality' and thus less deserving of financial aid (Lewis and Thomson 2019). As a consequence, it is vital to understand institutional temporalities as political acts rather than as 'natural' or 'inevitable'. Using this temporal lens, this chapter argues that the medical profession uses temporality and particularly the concept of emergency to further evade present and future processes of external scrutiny that challenges its medical power/knowledge. Whilst intersex variations are congenital and thus life-long they are often treated within the institution of healthcare as episodic, occurring at different points of the life course for acute and discrete periods of time. As a result, healthcare has been able to frame intersex variations as emergencies to create a sense of immediacy that does not just justify, but *necessitates*, medical intervention typically before the child is 12 months old (Lee et al 2006).

Our purpose for this chapter, therefore, is more than mere intellectual inquiry. Rather we intend our analysis to have practical effect for the way in which the State and Healthcare approach intersex embodiment. By revealing the responsibility gap created through healthcare's use of temporality, we argue that the temporal shift from emergency to emergence must be State-led, specifically through legislation. Highlighting the ways in which healthcare institutions construct temporality allows us to rethink the inevitability of clinical decision making in this area. For instance, the chronic (life-long) nature of intersex variances demands an understanding of the intersex body throughout the life-course. Such a focus allows for consideration of the child as emergent rather than an isolated and discrete temporal event somehow divorced from adulthood. An approach attentive to these issues of temporality is capable of considering solutions to social emergencies through the monitoring and adjustment of institutions – not through the alteration of children's bodies. Whilst acknowledging the plurality of different experiences of medical temporality, we argue that a psychosocial understanding of temporality in the context of healthcare is more in keeping with this temporal reframing as it is better able to consider the life course of the person. Furthermore, recent legislative shifts that are attentive to temporality such as Malta's Gender Identity, Gender Expression and Sex Characteristics Act 2015 may offer examples of best practice to policy makers whilst supporting psychosocial approaches. Building on this, this chapter offers the concept of deferability as an important new aspect in determining clinical and juridical best interests assessments. Whilst deferability has been discussed in some case law, its application has been ad-hoc and primarily arisen where there has been a dispute between parents or between parents and healthcare professionals. In this chapter we outline deferability as an important new tool capable of assessing institutional accounts of temporality allowing for delineation between emergencies and non-emergencies. As such, deferability offers legal theorists a way in which to monitor and evaluate the temporal constructions of societal institutions significantly adding to best interests assessments. Furthermore, this chapter offers guidance on how States should respond to and alter these institutional responses by highlighting the need for States to reconsider their role in temporal constructions of the body.

Temporality

Whilst culturally, it is acknowledged that time can go slowly or quickly, thicken or even seem to stop, this malleability of temporality is something that is rarely acknowledged within law or healthcare. Humans are unusual amongst animals in the sense that their understandings of time are dictated through objects (seen as objective measures) and institutions rather than relying solely on the environment (Birth 2012: 2). As Greenhouse notes “As new institutional forms developed - industrial workshops, the state, contracts and courts - different forms of time multiplied as they were juxtaposed in contiguous social fields” (1989:1636). Temporality, or the ways in which time is experienced and mediated through these institutions, has been an under-explored variable in the shaping of clinical and juridical judgment. Recently, temporality has received a renewed invigoration of interest from legal philosophers (Valverde 2009, 2015, Grabham 2011, 2014, 2016, Harrington 2016, McNeilly 2018, Gordon-Bouvier 2019). For these scholars time plays an important part in the ways in which law is understood; time is not linear, self-sufficient nor objective. In different contexts, spaces and jurisdictions time can be understood in quite different sometimes-competing ways.

Liberal approaches to time have tended to emphasise the universality, objectivity and linearity of time. Key to this construction has been the idea of "progress" through time that connect past societies to future ideals (Greenhouse 1989: 1638). Drawing upon Fitzpatrick, Harrington argues that the project of liberal legalism represents time "spatially as a series of discrete containers, helping to realize the positivist goal of sharply distinguishing law from its wider social environment" (Harrington 2016:74, Fitzpatrick 2001: 93). This 'liberal' conception of time is similarly reproduced in healthcare and shall be examined in more detail in the following section. Liberal understandings of time as 'discrete containers' has led to a lack of juridical focus on the life course. Instead, law has tended to catalogue its subjects through categories such as age with a concomitant understanding of events as distinct and singular. More often than not, therefore, law fails to identify the power relations that are played out in political constructions of temporality. As Emily Grabham notes "Time is expressed, and lived out, through an imminent sense of the forthcoming, but it is also the subject of power relations through which agents' engagement with the field can be directed or shaped" (Grabham 2011: 113). Temporality therefore is expressly political in state determinations of resources and responsibility. This leads Greenhouse to conclude that "If linear time dominates our public lives it is because its primary efficacy is in the construction and management of dominant social institutions, not because it is the only "kind" of time that is culturally available." (1989:1637)

Temporality is always constructed through our relations with the social – and must, consequently, be understood in terms of its political utility. Whilst the state has maintained monopolies over the construction of 'universal time' (Greenhouse 1989) even within the state temporality cannot be understood as singular or monolithic as different aspects of the assemblage of the state compete over the governance and meanings of time. Similarly, different institutions – also seeking to govern their own jurisdictions – will construct temporality in different and competing ways. As such, temporality must be understood as multiple and can be seen as a process of 'sorting' "through which human and non-human actors create the temporalities that structure legal and policy landscapes" (Grabham 2014:69). Focusing on the temporal aspects of law can help us to understand the reasons behind the internal inconsistencies within a number of policy developments or legal judgments. Such investigations help to uncover situations in which struggles over time can conceal "basic ethical and political values" (Harrington 2016:71) as well as illuminating the "normative underpinnings of apparently loosely related governmental projects" (Grabham 2011: 122). Moreover, such approaches push the temporal to the forefront of political and legal analysis acknowledging that temporality is "a co-product of action, or action itself, not a background for action" (Grabham 2014:73). Importantly for this chapter temporality can be understood as playing a central function in the justification of institutional responsibilities. Where previous work demonstrated how medical nomenclature enabled the State to avoid responsibility for intersex by deferring to an arbitrary medical jurisdiction (Garland and Travis 2020), this chapter argues that bio-medical power/knowledge has been further strengthened by healthcare's temporal framing of intersex. Temporality, it seems, is not only being used to justify non-therapeutic medical interventions on intersex infants, but it is also used to abrogate the responsibility of the medical profession in the face of mounting external scrutiny. The next two sections set out the problematic ways in which healthcare has framed intersex embodiment as an emergency.

Emergency

As medical technology advanced throughout the course of the 20th century, the medical profession increasingly expanded its jurisdictional remit to include intersex variations, reframing them as ‘diseases’ or ‘disorders’ of sex development which necessitate ‘fixing’ through medical interventions (Griffiths 2018a, 2018b, Fausto-Sterling 2000). In many ways, the medical timeframes of intersex embodiment remain reliant on the early work of John Money who claimed that “age eighteen months was the temporal limit for deciding which gender a child would be raised, since during this period gender identity and role should be stabilized….” (Meoded Danon 2018:91). The first eighteen months of childhood remain the medical professions’ ideal time for these surgeries to take place (Lee et al 2006). This medical co-opting of intersex has meant that this type of embodiment has become understood as temporal – depicted by key medical professionals (notably endocrinologists, surgeons and urologists) as a discrete state of emergency in childhood that becomes apparent upon the discovery of an intersex variation. Whilst we acknowledge this state of emergency is co-produced through the social anxieties of parents, as we will discuss further in this chapter, there are alternate approaches to intersex embodiment that might serve to deescalate the anxieties of parents. Healthcare professionals, and their framing of intersex embodiment serve as the dominant actors in the temporal construction of the body. This medical framing powerfully serves to justify the ‘gender assignment in newborns’ as a necessity arising from the intersex variance in question. As Meoded Danon notes “the diagnostic timeframe for intersex bodies… aims to speed treatment decisions and medical interventions for intersex babies and children in order to assign their bodies to a particular gender” (2018: 90). The ‘hows and whens’ of medical intervention serve to illustrate their inevitability even where ‘the child’ and family members are involved in the decision-making process. This viewpoint is typical of a dominant biomedical narrative that understands intersex embodiment as a state of emergency solely located in childhood (Fausto-Sterling 2000) or as an exception to professional standards around bodily integrity, cosmetic surgery and consent (Davis and Murphy 2013, Harrington 2016).

However, much recent work around intersex and non-therapeutic medical intervention has sought to disentangle immediate and deferrable interventions (Monro et al 2017, Amnesty International 2017, Garland, Lem and Travis 2019, Horowicz 2017, Zillén et al 2017, Garland and Slokenberga 2018) particularly given that nearly all intersex variations do not threaten the life or health of the individual, but may render the genitals as 'atypical'. Congenital Adrenal Hyperplasia (CAH), for example, is one of the most common forms of intersex variation and the treatment protocols developed for it have had wide ranging implications for the clinical management of other intersex variations (Newbould 2017). CAH is a variance whereby some of the hormones (cortisol and aldosterone) within the adrenal cortex are absent. The consequence of this can be life threatening in that the individual cannot retain salt and thus requires immediate life-saving hormonal treatment. In addition, CAH can lead to the overproduction of testosterone which causes the infant to have ambiguous genitalia. Thus, when an infant is born with ambiguous genitalia, it *may* be an indicator of CAH and therefore necessitates immediate tests to ensure that the infant does not have salt-wasting CAH. However, the ambiguous genitalia are not – themselves - life-threatening. Nevertheless, there has been a medical reluctance to distinguish between the CAH emergency and the CAH resulting in genital ambiguity (Newbould 2017). This has meant that historically treatments to correct life threatening salt-wasting have been done in conjunction with the cosmetic construction of the genitals. 'Fixing' the genital ambiguity has been depicted as part and parcel of 'fixing' CAH. Yet, even while some intersex variations are accompanied by a certain level of medical emergency it is still possible to distinguish between immediate and deferrable interventions. Clearly, we can see a distinction between the necessity of life-saving surgery and the deferability of surgery conducted for aesthetic or social reasons. Whilst salt-wasting is an inherent material issue that requires medical support in order to live, the need to 'normalise' ambiguous genitalia is profoundly shaped by the embedded cultural and societal contexts in which intersex embodied people find themselves.

Healthcare professionals' claims of emergency are thus exposed as social, rather than medical. Nonetheless, the construction of emergency has important legal effects on law. In negligence cases, for example, it is easier for a defendant to show that they acted reasonably and met the standard of care in an emergency situation.[1] Whilst international consensus statements have favoured the idea of deferring surgical intervention healthcare practitioners continue to believe that these surgeries relieve parental anxieties and so routinely practice these surgeries (Liao et al 2019). The focus on familial anxiety highlights these issues as social rather than arising from the intersex variation itself. Emily Grabham highlights two medical temporalities that undergird these 'emergencies'; the "cascading time of sex development" and the "time of repair and retrieval" (2012:7). In the cascading time of sex development, sex differentiation is constructed as a linear development – clearly definable, traceable and mapable. As Grabham writes "sex is produced through a sequencing effect, where hormonal, gonadal and morphological stages follow on from each other" (Grabham 2012:8). These medical explanations are presented as 'natural' and deviations from this linearity as 'disordered' and in need of intervention in order to alleviate the social anxieties caused by such atypicality. Here, it is useful

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[1] See *Ng Chun Pui v Lee Chuen Tat* [1988] RTR 298, 302 per Lord Griffiths and *Wilsher v Essex AHA* [1987] QB 730, 749 per Mustill LJ.

to reflect on the term ‘order’ as meaning the arrangements of events in time. ‘Disorder’, in turn, is used as a temporal judgement meaning to ‘disturb the order of’.[2] The temporal roots of order and disorder then are useful for reflecting on the ‘inevitable’ and ‘natural’ progression of events that healthcare practitioners assume. Grabham notes how these temporal constructions of biological (fetal) development reinforce heteronormative and patriarchal understandings of sexuality and the passive feminine subject even at the hormonal and chromosomal levels (2012:9-10).[3] These temporal constructions of disordered sexual development are used to justify the concept of ‘medical emergency’ as a ‘reordering’ in the present. Thus, whilst medical emergency harbours an innate governing logic of presentism it is based within a medical understanding of abnormality anchored to past failures of the body to develop along ‘normal’ lines.

This maps onto the second of Grabham’s medical temporalities which she refers to as the “time of repair and retrieval” (2012:7). In relation to intersex embodiment, retrieval forms one of the underlying rationalities for surgery through the “refashioning [of] developmental time lines” (Grabham 2012:12). Thus, retrieval is reliant upon a nostalgic temporality that harks back to a developmental stage where the child was not intersex (Morland 2006, Griffiths 2020). Whilst such a stage never existed, it certainly cannot be retrieved and yet this logic continues to lie beneath medical justifications in this area lending further weight to the logic of medical emergency. The governing rationality of repair contains similar problems of temporality. Grabham highlights three particular problems with repair; incrementalism, follow-up surgeries and medical learning curves (Grabham 2012). Incrementalism pertains to a medical conceptual

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[2] We are grateful to David Griffiths for this point.

[3] Grabham highlights how popular accounts of the ovum are often represented as passive when in fact that are highly active and discrimianting in choosing the sperm cells that they envelop. (2012:9-10)

logic that considers surgeries as singular and isolated considering “one body part at a time” (Roen 2008:52, Creighton et al 2001, See also Fox, Thomson and Warburton, this volume). This type of medical approach fails to consider the cumulative effects that such surgeries have on the intersex embodied child as the temporal logic of emergency presents these interventions as isolated and discrete events. This is bound up with the second point, that of repeat surgeries. Unplanned follow up medical interventions after the initial non-therapeutic surgical/medical interventions on children are exceedingly common and range from vaginal dilation, to dependency on hormones after the removal of gonads, to repeat surgical procedures. One study found, for example, that 89% of genitoplasties (planned as one stage procedures) required at least one further major surgery (Creighton et al, 2001). In part, the high frequency of these follow ups occurs because of the young ages of the ‘patient’ and because of the (often) experimental nature of the techniques utilized upon them. As Grabham notes:

> Going back is a linear reversal or detour, the object of which is a moment in the past which is temporally different from present action…. In fact, locating the problem in the past enables what would otherwise be classed as ‘new’ procedures and provides a justifying context for the associated risks of those procedures. (Grabham 2012: 13)

Here, the understanding of intersex variations as episodic enables the ‘fixing’ mentality that characterizes the medical profession’s approach to intersex embodiment – even where the harms in need of repair have been caused by initial medical interventions. The final medical temporality that Grabham identifies is that of the learning curve. In this temporality, the justification for intervention is placed in the future – at an undefined time where treatments are improved. For Grabham, this allows “relatively unpracticed procedures to take place in the present, which may later become the object of ‘repair’ surgeries” (Grabham 2012:13-14). A recent study has confirmed the presence of these beliefs within the medical professional with participants “maintaining a high level of professional confidence in preserving clitoral sensitivity while normalising genital appearance" (Liao et al 2019:4). Poor results in surgeries are either attributed to older techniques or as unique to other teams (Liao et al 2019:4, Meoded Danon 2018: 91). Ultimately, this leads to a situation where "parents' and patients' decisions are not being guided by realistic risk information" (Liao et al 2019: 5). Intersex variations are still being constructed as something that can be 'fixed' even where these medical interventions ultimately harm intersex people.

Similarly located in an imagined future, as a justification of their position, some surgeons have made reference to social rather than medical concerns (or emergencies) such as "the locker room test" – referring to the idea that children may be bullied at school if their genitalia are revealed to their peer group (Griffiths 2020, Fausto-Sterling 2000, Meoded Danon 2018). In the largest study of medical professionals working with intersex children, Liao et al found that none of the participants had come across instances of children being bullied for their genital appearance (2019:3). Nonetheless, "unmanageable negative psycho-social consequences were generally assumed" (Liao et al 2019:3). Such justifications ignore the very real and immediate harms wrought through surgery on the child in the present in favour of focusing on imagined harms that locate the intersex person in a state of perpetual adolescence (in the locker room, at the urinal, dating, having sex) (for similar arguments in the context of disability see Fox, Thomson and Warburton, this volume).

At the same time, we can identify a competing temporal logic whereby both medical practitioners and parents (who are often important drivers of such surgeries) fail to engage with the very real concerns around sexual pleasure (or even infertility) of intersex embodied people post-surgery. Whilst in the preceding paragraph the spectre of sex was used to justify surgery – form of the genitalia seems to be prioritized over the pleasure of the intersex person.

Reconstructive surgeries often leave the individual with ‘functional genitalia’ but with very little sensitivity due to the removal of nerve endings and excess scar tissue. These disparities highlight the normative underpinnings of these interventions – both justifications conceal a medical concern with the preservation of the gender binary and heteronormativity being played out through constructions of temporality. Temporal aspects of medical conceptions that perpetuate the infantilization of the intersex person through episodic accounts of intersex variances thus have an important function in continuing to privilege the power/knowledge of the medical practitioner over and above the experiences of the patient, child, or intersex person. These surgeries, rather than helping to improve the lives of individuals actually serve to create lifelong negative physical consequences, lead to dependency on the medical profession and serve to damage the individual’s relationships with core institutions such as the family and education (Garland and Travis 2020, Meoded Danon 2018). Moreover, Meoded Danon notes the non-linear haunting effect of these medical interventions, where “early irreversible surgeries… are not necessarily forgotten over time, but rather remembered and present in various somatic responses” (2018: 89). This non-linearity also highlights that medical knowledge and constructions of time in this area are neither singular nor monolithic.

Notably, the medical conceptualization of intersex as an emergency not only diminishes the resilience of intersex embodied persons, but also serves as a mechanism through which the medical profession creates a future-proof jurisdiction that is (largely) free from external scrutiny (Garland and Travis 2020). At the time of decision-making, the medical profession has been able to avoid legal analysis of whether gender-normalizing surgery is within the child’s best interests and potentially prevent the intervention from taking place. Best interests assessments are used in health and child law to inform the decisions made on behalf of people who are unable to consent either through mental capacity, unconsciousness or childhood. Many of the cases concerning the assessment of best interests occur because of a clash between families and healthcare practitioners and their views about treatment (or its withdrawal) on patients who cannot consent. As Holman J. notes in *An NHS Trust v MB* [2006] EWHC 507 "Best interests are used in the widest sense and include every kind of consideration capable of impacting on the decision. These include, non-exhaustively, medical, emotional, sensory (pleasure, pain and suffering) and instinctive (the human instinct to survive) considerations." This is reflected in section 1(3) of the Children Act 1989 that focuses on the risk of any harm, the emotional and educational as well as physical needs of the child, and any of the characteristics of the child which the court considers pertinent. Given the amount of evidence being produced regarding the harmful consequences of gender-normalising surgeries, a strong case could certainly be made to demonstrate how these medical interventions are not in the child's best interests. While decisions regarding genital-normalising surgery on infants ultimately fall to the parents,[4] they must still be made in the best interest of that child.[5] However, litigation essentially relies on parental disagreement with medical practice and this is unlikely given that Healthcare's temporal construction of the body leaves little time nor space for parents to question such practice or to receive psychosocial support with regards to the social anxieties that arise in relation to parenting an intersex child.[6]

Accordingly, the medical profession is able to avoid external scrutiny while it plans and performs surgical interventions. This is not to claim that the Court's application of best interests would necessarily produce favourable outcomes for the intersex child. Certainly, academics have

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[4] Or those with parental authority as defined by s 3 Children Act 1989.

[5] Parents are bound by the same assessments as the courts. See e.g. *Gillick v West Norfolk and Wishbech AHA* [1986] AC 112 [184] per Lord Scarman.

[6] Cases that have come to court have revolved primarily around parental disagreement. See for example, *Re J (Child's Religious Upbringing and Circumcision)* [2000] 1 FCR 307

demonstrated how the Courts have often over-emphasised family integrity and parental wellbeing at the expense of the child's own interests (Horowicz 2017; Fox and Thompson 2005). Indeed, in the case of circumcision, the Court have actually entrenched male-genital cutting as a legitimate choice for parents (Fox and Thompson 2005). Accordingly, the medical profession (and parents) may be able to manipulate the best interest test through this logic of emergency depicting gender-normalising surgeries as necessary to 'correct' intersex children and thus to avoid psychosocial 'harm' (Horowicz 2017: 199). Nevertheless, the fact that decisions relating to gender-normalising surgeries are yet to even be considered by the Courts is problematic and allows the medical profession to maintain control over intersex bodies. These issues raise two important propositions. Firstly, that doctors are not interpreting best interests properly as they are failing to consider the adult the child will become or the child's interests over their life course. Secondly, when making judicial best interests assessments deferability must always (rather than rarely) be taken into account.

In the context of healthcare, external scrutiny and perceptions of malpractice are a significant threat in terms of its own economic and reputational security. Where the profession faces legal action for past interventions, it potentially faces financial penalties that will result from litigation and/or out-of-court settlements as well as potential criminal prosecution if an intervention was found not to be in the best interests of the child.[7] At the same time, reputational threats to medical power/knowledge challenge the jurisdiction of the medical profession itself and could detrimentally impact upon the way the NHS is publically funded and the social status of medicine more broadly. This is particularly pertinent given that the NHS "is subject to reform,

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[7] This would mean that the parents did not have the authority to consent to practice.

cost-cutting and political compromise" (Fenton 2013: 139). With this backdrop, we consider how the medical profession's focus on temporality depoliticizes the issues involved.

Given the increasing volume of evidence of the harms of these practices, the choice to not view intersex embodiment over the whole life course must be viewed as strategic institutional preference to 'future-proof' its jurisdictional claims. The consequences of this strategy are revealed where medical professionals are directly challenged by intersex adults on the interventions that were performed upon them. Medical practitioners are able to distance themselves from these early events in two ways; firstly, by suggesting that practice has changed, and, secondly, by highlighting that they, as individuals, were not involved in these historic events. These strategies allow the medical profession to claim that 'time has moved on', that 'that was then and this is now', and that 'practice has changed' creating a temporal gap between the knowledge of the intersex adult and current medical practice. A recent example can be drawn from an article published in *European Urology* that responds to the Council of Europe Human Rights Commissioner's Issue Paper on Human Rights and Intersex People. In this article, the authors contend that the Human Rights Commissioner "does not recognise what has changed nor what is now widely understood as best practice in the field" (Cools et al 2016: 408). They go on to add that "What the paper calls ''current medical approaches'' is to a large extent inconsistent with recently published data and current medical practice" (Cools et al 2016: 408). Similar examples can be found in Norway where physicians wrote an open letter to a national newspaper maintaining that medical practice had changed and intersex activists were not fully informed (Wæhre et al 2017). Medical professionals and the institution of healthcare are accordingly able to avoid taking responsibility for the continuing harms of non-therapeutic medical interventions whilst simultaneously further disempowering intersex voices by challenging the individual's knowledge base. Nonetheless, the issues raised by the intersex community are not dependent on the improvement of technique but the dangers inherent to non-consensual non-therapeutic medical interventions.

This temporal disconnect presents intersex adults as uninformed and lacking the current knowledge to be able to make a justifiable evaluation of ongoing medical practice. This method of distancing and discrediting allows the medical profession to raise doubts about the individual's reliability and whether the institutional harms actually occur in the manner the individual claims. As such, intersex activists must rely on the academy to 'objectively' account for their experiences. These challenges to intersex knowledge continue despite evidence demonstrating that practice has changed very little over time (Monro et al 2017, Roen 2019, Creighton et al 2014). Consequently, where doctors are performing interventions in the present on intersex infants as research demonstrates still occurs (Monro et al 2017, Creighton et al 2014, Liao et al 2019) it will remain possible for the medical profession to employ similar strategies if and when they are challenged in the future by the adult that intersex child becomes. Resultantly, it becomes possible to see how logics of emergency and surgical/medical progression are used to delimit professional knowledge and prevent external scrutiny. The discrete event of 'fixing' that happened in the individual's childhood is disconnected from their current lived adult experience. This disconnect is bolstered by the fragmentation of the medical profession into specialties and sub-specialties that continue to see medical interventions as discrete issues – particularly in adulthood where access to Multi-Disciplinary Teams specialized in intersex variations is less common.

Moreover, the episodic nature of the emergency has prevented attempts to reconsider professional best practice in this area and protected current iterations of best practice from serious scrutiny. Here, the temporal framing of an emergency enables the bio-medical narrative of intersex to maintain its authority in these matters and deflect criticism from other actors such as parents and/or other healthcare professionals. In these cases, "clinical imperatives can set temporal horizons to the process of legal decision making itself" (Harrington 2016: 80). Both Harrington (2016) and Davis and Murphy (2013) have highlighted medicine's ability to act as a 'state of exception' within law. As Davis writes,

> Constructing intersex as a medical emergency allows doctors to circumvent professional medical ethics that would normally prevent them from performing swift, irreversible, and medically unnecessary surgeries on children's bodies…. Although doctors tend to claim that they are merely information providers, it is important to keep in mind that they make treatment recommendations from a position of power and authority over the intersex "emergency" they create. (Davis 2015: 118).

Understanding the temporalities involved in determining these states of exception allow us to see how legal standards are "subordinated to a clinical understanding of the public good" (Harrington 2016: 82). Constructions of intersex variances as 'fixable' play a significant role in altering the application of institutional standards away from the (supposedly) universal and abstract temporality of human rights and towards an individual and immediate clinical understanding of 'best practice' (which may fail to consider the long term psychosocial and health outcomes of the intersex embodied person). Such cases are marked by "A loss of reason [that is] central to the legal and medical construction of the emergency" (Harrington 2016: 82). The immediate focus of best interest creates a lack of recognition of the adult that 'the child' will become. Whilst medical guidelines pay lip-service to the way these interventions may impact into adulthood these rarely factor into clinical decision making. Conversely the spectre of the 'disordered' intersex adult (who has not undergone surgery) continues to haunt the imagination of medical professionals. As a consequence, the construction of intersex embodiment as an emergency solely located in childhood prevents proper discussion around the deferment of medical interventions.

Certainly, such temporalities have informed the discourse around intersex embodiment constructed through the concept of ‘medical emergency’ (Davis 2015) and the immediacy that such a term inspires. As we have seen, in these contexts it is the healthcare professionals’ anxieties around normative bodies that dictate the temporality rather than the intersex variance. Emergencies require action with medical logics determining that to do otherwise would be neglectful and risk legal challenge. Moreover, the concept of emergency strengthens bio-medical hierarchies through its dictation of the order in which professionals are introduced into healthcare management (as well as the resources allocated to them). As we have seen, the logic of emergency demands a level of immediacy which prevents not only practitioners from really reflecting on the ethical nature of their acts, but also prevents parents from being given an appropriate timeframe (or psychosocial support) for making decisions that may have lifelong implications for their child. The ways in which options are framed, therefore, becomes crucial to the decisions that parents make (Streuli et al 2013). For example, in a recent study by Garland, Thomson, Travis and Warburton it was found that in some NHS trusts, pediatric surgeons would be present at the initial meeting with parents to discuss their options (forthcoming). Surgeons are a key component in portraying intersex issues as episodic and immediately ‘fixable’ through medical intervention. Furthermore, international research in this area found that psychologists were only available for face-to-face discussions with parents in 53% of centres (Kyriakou et al 2016). Such research highlights the shaping effect that the make-up of the medical team can have on parental decision making. This temporal framing thus reifies the idea that the child’s intersex variation is an emergency to parents. Temporality is a crucial element therefore in the privileging of clinical judgment and the protection of medical professionals from serious scrutiny. The view presented so far roughly characterizes the dominant understandings of intersex care espoused by endocrinologists, urologists and surgeons. However, there have been calls, particularly in the psychological literature, to shift to a psychosocial model of care for intersex people that offers a distinctly different understanding of intersex temporality.

Emergence

This section argues for a shift in healthcare away from ‘fixing’ intersex variances and towards having the institutional support systems in place that will enable intersex embodied people to flourish. In part, this need for care over the life course has been recognised in leading medical guidelines on intersex variations. In the 2006 intersex consensus statement, for example, psychosocial care provided by mental health practitioners was seen as a key part of managing intersex variations (Lee et al 2006:E492). When the consensus was updated ten years later, it was emphasised that “education and psychological support was needed … to [allow individuals to] make sense of the condition, relate to their community and establish relationships” (Lee et al 2016:170). Notably, psychosocial support is considered crucial both for the child *and* their family to ensure that they are capable of making appropriate and informed decision-making in relation to their own healthcare management. Indeed, one of the leading providers of intersex healthcare in the UK was criticised recently for failures to provide psychological support to patients (Kirkland 2017). However, this lack of focus on care over the life course is not an isolated practice; in a recent study with parents of intersex children Bennecke et al (2015) found that only half of the parents who identified a need for psychological support received ‘adequate’ provision. This is problematic, as the birth of a child with an intersex variance can often be a time of immense distress for parents. As well as the usual complications, emotions and exhaustions of parenthood they are also faced with a need to understand information relating to complex medical and genetic variations, stigma, ambiguity regarding gonadal tumour risk, a lack of certainty about future gender identity, and uncertainty as to fertility potential (Ernst et al 2018:1). Psychosocial care, therefore, forms a key component of supporting intersex people over the life course. It is vital for both intersex individuals and the familial institutions in which they find themselves.

Offering alternative care pathways to children and families should be an important feature of the Multi-Disciplinary Team that deals with intersex people, as they are particularly capable of reframing temporal logics of the body from emergency to a perspective capable of considering the adult the child will become. Consideration of psychological well-being over the life-course is necessary for fully appreciating best interests assessments. This shift in temporality is in keeping with recent legal work on bodily and embodied integrity that understands the child as emergent (Fox and Thomson 2017, Fox, Thomson and Warburton, this volume). This work seeks to integrate “physical and psychological dimensions of integrity in recognition of the child’s emerging legal subjectivity” (Fox and Thomson 2017: 503). Such reconceptualisations of the body help to unpack its complexity by acknowledging it as both physical and psychological, dependent and embedded in a web of institutional and societal relationships. Helpfully, however, these relational accounts do not simply collapse into a veneer for prioritising the will of the family (Fox and Thomson 2017:523) instead, it shifts integrity to the core-value of best-interests decision making (Fox and Thomson 2017:524). In seeing the body as emergent it places emphasis on the ways in which embodied integrity allows the conditions for “self-determination that enable the individuated self, and contrasts sharply with the static, propertied, and bounded notion often envisioned in legal discussions of conventional integrity” (Fox and Thomson

2017:529). We would add, that these views also seem to characterise dominant medical thinking in the field of intersex healthcare management. An approach grounded in embodied integrity, therefore, is much more suited to considerations of the body over the life course. Such an approach is attentive to the "memory of the flesh and the ways in which bodies remember" (Meoded Danon 2018: 95). We would therefore support a shift from the current endocrinologist/urologist based model to a psychosocial model with "psychological health care [being] the foundation upon which other kinds of health care may be built as needed" (Roen 2019: 517).[8] Such an approach is in keeping with a wider understanding of best interests that encompasses multiple approaches and contexts. This is evidenced in *Aintree v James* [2013] UKSC 67 where Lady Hale highlighted that psychosocial concerns would be paramount in best interests assessments. As law and psychology are increasingly brought into contact in their determinations of 'selfhood' this embodied understanding may represent a progressively more important (and mutually constitutive) co-production of bodies.

Where psychosocial care has been offered as a key aspect of intersex healthcare management there are growing concerns about *when* this care is introduced (Liao et al 2014, Garland, Thomson, Travis and Warburton forthcoming) highlighting the battles for the construction of temporality that exist within institutions. If a psychosocial care model does become dominant it leaves the current 'emergency based' endocrinologist dominated model open to criticism. As a result, as Liao et al note, although "multi-disciplinary care pathways for … DSDs often allude to the importance of psychological interventions, [they] … are usually set up

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[8] We note here that we feel a tentative pang of concern around re-embedding psychology into every aspect of state response. We would highlight, however, the shifts within psychology from its origins as a disciplinary regime focused on norms to its current emphasis on care. Whilst these shifts warrant broader consideration, unfortunately, this current chapter does not have the space.

without due consideration of them" (Liao et al 2014: 131). As previously mentioned the presence of a surgeon at the initial discussions with parents around their choices means they are well placed to influence the parents' decision-making process before parents come into contact with any form of psychosocial support (Garland, Thomson, Travis and Warburton forthcoming). Thus, while Liao notes "it is obvious that parents affected by DSD first and foremost require sustained psychological support … this does not seem to be the central focus in paediatric management" (Liao et al 2010:). This approach would require a shift in institutional thinking away from intersex variances as episodic towards supporting intersex embodiment over the whole of the life course.

Yet, without State intervention, the medical profession has been reluctant to change and instead psychosocial care has been an afterthought, subject to complex internal hierarchies and claims of territory within the medical profession. As Liao and Simmonds note, "the risk for psychological services of being an emotional repository without any capacity to influence the overall service ethos is relatively high" (2014). Offering alternative care pathways has not been the case under the current endocrinologist dominated model where clear hierarchies between healthcare professionals remain persistent (Liao et al 2015; Liao et al 2010). Rather the temporal strategies being employed by the medical profession are designed to shield them from criticism, instead of acting in the best interests of intersex people. In the wake of these internal problems, reform led by the medical profession may not be appropriate and thus action must be State-led and focus on institutional reform. The State must take responsibility also for the resources that are available (Fenton 2013: 139) to ensure that healthcare institutions can afford practitioners who are adequately trained to provide psychosocial support from the outset. Moreover, reform must consider the ways in which the medical profession interacts with other societal institutions and ensure that they appropriately support intersex embodied individuals.

Deferability

Thus far, this chapter has demonstrated the need for a temporal shift in medicine that frames intersex variations in terms of emergence rather than emergency. Depicting such variations as an emergency has led to harmful and non-therapeutic medical interventions being performed on intersex individuals before they are able to consent. In this section we engage with Helen Stalford's contention that "in reality best interests assessments are unnervingly instinctive and highly contingent on the subjective assessment and value framework of the decision-maker" (2017: 43). This chapter adds to this by focusing on the ways in which temporality dominates the framing of best interests assessments. In this section we offer the concept of 'deferability' as a way of countering this temporal dominance by testing whether clinical practices that interfere with a subjects embodied integrity can be understood as emergencies. Put simply, such a test asks whether medical interventions can be deferred or not. If they cannot be deferred the situation is an emergency. If the practice can be deferred then it will be in the child's best interests to wait until the child is old enough to give consent or until the intervention can no longer be deferred. Deferability, therefore, is presented as an important new component of best interests assessments that assesses institutional accounts of temporality allowing for delineation between emergencies and non-emergencies without relying upon more loaded and ambiguous terms such as 'necessity'.

Malta can perhaps be seen as the first state to engage with intersex issues in this temporal manner. Section 14 Gender Identity Gender Expression and Sex Characteristic Act 2015 (Malta) states:

> It shall be unlawful for medical practitioners or other professionals to conduct any sex assignment treatment and/or surgical intervention on the sex characteristics of a minor which treatment and/or intervention can be deferred until the person to be treated can provide informed consent.

Malta's legal provisions in this area draw upon nascent understandings of embodied integrity postponing interventions until the child can provide informed consent or until such time as the interventions become no longer deferrable. Intersex activists have described this legislation as the ‘gold standard’ of legal recognition (Garland and Travis 2018). By placing bodily integrity at the centre of reforms, commentators and critiques have commended Malta for enacting real protections for the intersex community which recognise the legitimacy of the corporeal experiences of intersex individuals (Garland and Travis 2018, Ní Mhuirthile 2018). Decoupling legal regulation from the medical narrative of intersex enables individuals to more fully integrate and participate in society. It places decisions surrounding surgery and gender identity in the hands of the individual rather than in the hands of parents or medical professionals. This approach draws attention to the manner in which “the value of embodied integrity lies precisely in how it underpins the child's emergent subjectivity, meaning that her needs are never synonymous with those of others, or merely an extension of them” (Fox and Thomson 2017: 523). Such an account powerfully challenges the privilege of the medical profession in determining the temporality of intersex experience and allows for new biographical narratives to flourish.

The temporal notion of 'deferability' also fits neatly with a best interests assessment that places embodied integrity as its core legal value (Fox and Thomson 2017). While s1(3) Children Act 1989 offers a number of factors to be taken into account, *Re A (medical treatment: male sterilisation)* [2000] 1 F.C.R. 193 demonstrates how ultimately best interests assessments are a balancing act. Thorpe L.J. stated that:

> Pending the enactment of a checklist or other statutory direction it seems to me that the first instance judge with the responsibility to make an evaluation of the best interests of a claimant lacking capacity should draw up a balance sheet. The first entry should be of any factor or factors of actual benefit…. Then on the other sheet the judge should write any counterbalancing dis-benefits to the applicant…. Then the judge should enter on each sheet the potential gains and losses in each instance making some estimate of the extent of the possibility that the gain or loss might accrue. At the end of that exercise the judge should be better placed to strike a balance between the sum of the certain and possible gains against the sum of certain and possible losses. Obviously only if the account is in relatively significant credit will the judge conclude that the application is likely to advance the best interests of the claimant.

We would note that whilst there may be some benefits to non-therapeutic medical interventions asking whether they are deferrable (i.e. that the benefits could still be accrued if the intervention was postponed) significantly enhances the use of best interests. A focus on the deferability of interventions allows them to be seen as valuable but also recognises that they can be postponed enhancing the autonomy of the intersex person. By using deferability, judges and clinicians can bring together two important values that may (and, indeed, often have) otherwise been in conflict. This approach is not unprecedented within English Courts. In Re D [1976] 1 All ER 326, for example Heilbron J held that the sterilization was not in the interests of an 11 year old girl with Soto Syndrome at least at that time as she might develop so as to be able to make her own choices later in her minority or in adulthood. The mother, concerned about her daughter's growing sexual awareness, wanted her sterilized to prevent pregnancy. Heilbron J recognized the procedure was neither medically necessary nor indicated and concerned that D would later understand its implications:

> …where the evidence shows that her mental and physical condition and attainments have already improved, and where her future prospects are as yet unpredictable, where the evidence also shows that she is unable as yet to understand and appreciate the implications of this operation and could not give a valid or informed consent, but the likelihood is that in later years she will be able to make her own choice, where, I believe, the frustration and resentment of realising (as she would one day) what had happened could be devastating, an operation of this nature is, in my view, contra-indicated.

More recently, the Court in *Re L and B (Children: Specific Issues: Temporary Leave to Remove from the Jurisdiction: Circumcision)* [2016] EWHC 849 (Fam) settled a disagreement between parents over whether two boys should undergo circumcision based on the father's religious beliefs. Here the Court chose to:

> … defe[r] that decision to the point where each of the boys themselves will make their individual choices once they have the maturity and insight to appreciate the consequences and longer term effects of the decisions which they reach. Per Roberts J at [143]

Both of these cases demonstrate the benefits that deferability can bring. While neither Court denied the value of either procedure, they were able to use something akin to deferability to separate child welfare concerns from social and familial anxieties and distill the necessary from the unnecessary. However, while deferability as a concept is not wholly alien to judicial reasoning, cases using this approach are few and far between and many cases concerning unnecessary medical procedures have failed to disentangle parental interests from best interests assessments (Horowicz 2017; Fox and Thompson 2005). Consequently, we argue that deferability needs to be built in to juridical decision-making tools.

Moreover, the benefits of this temporal dimension are further supported in the leading case of *Re F (mental patient sterilisation)* [1990] 2 A. C. 1. Here Lord Goff considered in detail the link between best interests and emergency. For him, emergency may give rise to the notion of necessary treatment potentially suspending the need for consent. However, he also notes that emergencies cannot be permanent. As he writes:

> Furthermore, in the case of a … stroke victim, the permanent state of affairs calls for a wider range of care than may be requisite in an emergency which arises from accidental injury. When the state of affairs is permanent, or semi-permanent, action properly taken to preserve the life, health or well-being of the assisted person may well transcend such measures as surgical operation or substantial medical treatment and may extend to such humdrum matters as routine medical or dental treatment, even simple care such as dressing and undressing and putting to bed.

For our purposes, this distinction echoes our own delineation between emergency and emergence. Emergence requires support from a range of different social institutions – in this chapter we have concentrated primarily on psycho-social care but this could be added to by, for example, law, social care and education. Here, Lord Goff, considers the life course rather than just the immediacy of the issues dictated through the temporality of emergency. Law is capable, therefore, of disrupting the temporalities offered by the medical profession. Whilst Lord Goff does not consider the concept of deferability it is easy to see how such an approach could bolster this existing understanding of best interests.[9] Building on this, the concept of deferability allows an incremental approach to intersex health to be undertaken. Deferability, in this context, does not mean simple postponement – as Lord Goff notes in his discussion of the stroke victim it actually requires higher levels of assessment. Monitoring for cancer symptoms in intersex people, for example, would become prioritised over and above the removal of tissue on the basis of perceived cancer risks. Whilst this could be argued to increase the focus on already over-surveilled bodies emphasis on deferability following an embodied integrity approach allows us to give precedence to non-invasive forms of care (Fox and Thomson 2017). This need for regular

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[9] Note that if faced with two options that are equally good the courts should select the least invasive (contained in Mental Capacity Act 2005 but reflects statements at common law in sterilisation cases prior to the Act coming into force).

and consistent health checks means that deferability encourages institutional support over the life course to assess for potential sources of harm. Such an account recognises the potential for intersex bodies to have increased cancer risks but also contextualises them against cancer risks in general and the ways in which these are managed. This attentiveness to intersex embodiment over the life course stands in stark contrast to the 'fixable' child's body but is in keeping with emergent health law perspectives we have identified (Fox and Thomson 2017, Fox, Thomson and Warburton, this volume).

This shift in focus from intervention to monitoring requires engagement from the state, the medical profession and the law. Indeed, the resource implications stemming from the preceding discussion necessitate some level of state involvement. Despite the benefits of a legal engagement with deferability we do not believe that meaningful change can occur without the serious engagement of the medical profession with these issues. Blanket legislative prohibitions that do not engage with the medical profession will undoubtedly fail to improve standards in this area. Such legislation will not contain the nuanced level of detail required on this complex issue to ensure that intersex individuals are really protected within clinical settings (Garland, Samuelson and Travis 2019).

In order to carefully map out recommendations for updated guidelines in this difficult field, expertise in medicine, ethics and law as well as the intersex community are needed to ensure the emergent body of the intersex embodied child is respected. Part of this will involve providing specific funding to ensure that healthcare services have adequate resources to provide psychosocial care. However, as we have seen, the failure to sufficiently provide psychosocial support may not just be due to a lack of resources, but may be due to complex medical hierarchies and a temporal depiction of intersex that paints immediate surgical treatment of intersex bodies as necessary. The State must find a way of reframing conceptions of temporality within medicine and we offer the example of Maltese legislation as one potentially fruitful avenue of exploration.

Legislation, similar to that in Malta, along with a broader shift in the clinical management of intersex care towards deferability and monitoring through psychosocial care may begin to provide adequate state support to intersex embodied people. It is in this context that healthcare must be transformed to ensure a psychosocial approach to care that focuses on the emergent body. It is clear that in its current form the systemic hierarchies and internal problems within healthcare mean that the institution is not best placed to self-regulate on these issues. The lip-service that has been paid to psychosocial care and the failure to truly incorporate alternate pathways to care thus far is testimony to its inability to self-govern in this area. While it is commendable that the NHS has developed a specialised commissioning group looking specifically at intersex variations, to date no healthcare service has engaged with the necessary temporal shift in understandings of intersex without State intervention. Thus, reform must be State-led and this will require a reconceptualization of responsibility as, historically, the UK Government has characterized these issues as solely the responsibility of the NHS (Garland and Travis 2020).[10] While there is a greater shift by the UK government towards politically recognising the medical treatment of intersex persons (having recently issued a Call of Evidence (2019) on this matter), an effective State will need to ensure that not only are greater resources provided to healthcare to ensure adequate funding is provided for psychosocial support, but the

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[10] See the UK's response to criticism from the 72nd Session of the UN Committee on the Rights of the Child 23 May 2016, at <http://stop.genitalmutilation.org/post/UK-Questioned-over-Intersex-Genital-Mutilations-by-UN-Committee-on-the-Rights-of-the-Child>.

State will also need to address systemic inequalities that pervade other social institutions (Garland and Travis 2018).

Resultantly, we offer the concept of deferability as a key component of ensuring embodied integrity. In particular, deferability can be seen as a legal tool that assesses institutional accounts of temporality allowing for delineation between emergencies and non-emergencies. Clinical and juridical decision making, we would argue, must include deferability in its accounts of best interests decision making. This will allow for institutional accounts of temporality to be appropriately evaluated. More speculatively, we also posit that deferability may have some purchase in other areas where temporality is relied upon. Assessment of 'national emergencies' for example and their subsequent derogations from human rights law might usefully be seen through this framework. Moreover, this framework could be applied to policy making more generally. Assessment of the threat of climate change, for example, might also be understood through a lens of deferability and emergency.

Conclusions

This chapter has demonstrated how the logic of emergency is being used by the medical profession to justify non-therapeutic and harmful interventions on intersex infants. These emergencies are not medical, but are in fact social emergencies and produce harmful lifelong negative consequences for intersex embodied people. Medical practice must shift its temporal understanding of intersex to focus on the emergent body. This reframing will enable care pathways to better conceptualise the life course of the individual and is more in keeping with best interests and children's rights. The notion of emergency not only justifies early interventions, but it also operates in a way that prevents external scrutiny over practice. Medical professionals are able to circumvent ethical issues and hinder discussions about best practice grounded in Human Rights frameworks or best interests assessments. Entrenched hierarchies that place bio-medicine at their apex prevent healthcare from meaningfully incorporating psychosocial support within care pathways. Moreover, emergency logics and the episodic construction of intersex enable medics to deflect criticism received from the intersex adult that the child becomes. Ultimately, then it is the State who must intervene and reconsider its role in the construction of time. Utilising psychosocial care and legal conceptions of deferability will allow individuals greater voice in the choices made about their bodies. It will prevent non-therapeutic interventions being performed without the individual's consent, whilst still allowing for the possibility for the individual to choose to consent to such procedures once they are able to meaningfully partake in the decision-making process.

Moreover, this chapter has sought to highlight the role of temporality in the construction of bodies within healthcare. Such an approach can highlight the plurality of temporality that can exist within healthcare approaches – the differences in understanding of issues between, for example, endocrinologists and psychologists can be traced, to some extent, to their reliance upon different temporal registers. In addition, we have demonstrated the ways in which temporality can be used to depoliticise issues – subtly shifting the ways in which claims of harm or abuse are framed. Such an approach may have wider appeal when examining the ways in which the body interacts with healthcare and the state more broadly. Bodies are constituted through temporal frameworks and the way these are constructed are always a political act. As such, legal and legislative responses to healthcare must also be understood as temporally and politically loaded. Careful attention to temporality is thus required to ensure that state and legal approaches to the body are in keeping with notions of social justice. This chapter also offered deferability as an important new component of clinical and juridical accounts of best interests assessments. Deferability, as we present it, proposes a significant tool for assessing institutional accounts of temporality allowing for greater delineation between emergencies and non-emergencies. In doing so, deferability builds upon and adds to the prominence of embodied integrity as a key component of legal and medical practice whilst also potentially adding to areas as diverse as human rights derogations and climate change. While case law has demonstrated the utility of this approach, its use has been sparing and ad hoc, thus, we argue that it should be built in to both clinical and judicial decision making.

Reflecting on our own experience of time we also note that this chapter advocates a linear notion of political progression and perhaps falls into the 'liberal' understanding of time that we highlighted at the outset. Whilst we recognize this we must also acknowledge our place within the intersex community with its own political agenda and motivations. The intersex community's desire for an end to non-therapeutic medical interventions itself denotes a clear and unambiguous temporal register and sense of direction. As a result, we have allowed our political loyalties to the intersex movement to shape our own understandings of time. Following this, the true social emergency is around medical standards and, following the twitter hashtag popularised by intersex activists in the wake of the #metoo movement, #timesup.

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